MEDICO®
INSURANCE COMPANY

Medico Insurance Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306

www.GoMedico.com
Phone (toll-free): 800-228-6080

Application for Dental Insurance

Requested effective date of new policy (optional)

_____
MM/DD/YYYY

Requested effective date must be after the application date. If no effective date is requested, the effective date will be the day the application is approved by the company.

Policy delivery

Upon approval of this application, the policy will be delivered to the applicant by mail.

Part A: Applicant information (please print)

Primary applicant information

Full name of applicant: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Age | Gender

Social Security number | Phone number | Email address

Residence address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Mailing address *(if different than residence address)* | City | State | ZIP code

Spouse information *(if no spouse is applying, leave blank)*

Full name of spouse: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Age | Gender

Social Security number | Phone number | Email address

Check here if address is the same as the primary applicant's address: ❒

Residence address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Mailing address *(if different than residence address)* | City | State | ZIP code

Replacement information

1. Do you or your spouse (if applicable) have any dental insurance currently in force? ❒ Yes ❒ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? ❒ Yes ❒ No

   If "Yes," please provide the following:

Company name | Policy number | Type of coverage

Multiple policy discount information

Are you or your spouse (if applicable) currently covered by or applying for a Medicare Supplement or Final Expense policy with one of our companies? ❒ Yes ❒ No

If "Yes," please provide the policy number or the company you are applying with: _____

Part B: Benefit (check the desired options)

Base plan *(choose one)*:

❒ Gold: $1,000 ❒ Platinum: $1,000
❒ Gold: $1,500 ❒ Platinum: $1,500

Optional riders *(choose one)*:

❒ Calendar Year Maximum Buyup benefit rider
❒ Calendar Year Maximum Carry-over benefit rider

Part C: Payment options

Make all checks payable to: Medico Insurance Company (Do not make checks payable to the producer or leave payee line blank.)

Method of payment:	**Frequency of payment:**			
❒ Automatic bank withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually
❒ Credit/Debit card	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually

Part D: Application agreement

Applicant certification

I hereby apply to Medico Insurance Company (the Company) for a Dental Insurance Policy to be issued solely and entirely in reliance on my answers. The answers, which I adopt as my own, are true, full, and complete and have been accurately recorded. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid and the policy is delivered and accepted by me. I have received the Outline of Coverage for the policy (in states where required by law).

No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, or through wage adjustments or other means of reimbursement.

NOTICE: Any person who knowingly and with intent to defraud or damage files a claim containing false, incomplete, or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.

The Company may have the right to deny benefits or rescind your policy for fraud or intentional misrepresentation of material fact on your application.

I am applying for this Dental Insurance Policy. The policy provides dental benefits only. Review your policy carefully.

X _____
Applicant's signature Date (MM/DD/YYYY)

X _____
Spouse's signature *(if applying)* Date (MM/DD/YYYY)

Producer's certification

I certify the information in this application was provided by the applicant and correctly recorded. If the applicant is Medicare eligible, I have provided the applicant a link to the Medicare Buyers Guide at www.GoMedico.com/Products.

_____
Producer's printed name Producer's number

X _____
Producer's signature Date (MM/DD/YYYY)